MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Vision Care

March 2006 • Bulletin 337

Contents

Convert Early to HIPAA-Compliant Electronic Claim Transactions

Effective July 1, 2006, regardless of date of service, the Vision Computer Media Claims (CMC) proprietary format transaction will not be accepted for vision services. Additionally, the (Professional) Medical Data Specifications (part of the *837 Version 4010A1 Health Care Claim Companion Guide*) have been updated to include the required segments for vision claims for dates of service on or after July 1, 2006. The (Professional) Vision Data Specifications will no longer be valid as of July 1, 2006. The companion guides are available on the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking "HIPAA" from the home page, then "ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications."

To ensure that electronic vision claims are accepted by Medi-Cal beginning July 1, 2006, providers submitting electronic claims in formats other than the HIPAA-compliant ASC X12N 837 v.4010A1 transaction should begin conversion enrollment and approval activities immediately. Providers using outside vendors for billing should ensure that these vendors submit electronic claims in a HIPAA-compliant electronic format by the above date as well.

Enrollment and approval of HIPAA-compliant electronic claim submitters can take 30 days or more to complete. Therefore, providers are strongly encouraged to begin the transition immediately to be compliant prior to July 1, 2006. Regardless of the date of service, non-HIPAA compliant formats will not be accepted as of July 1, 2006.

To enroll, test and begin submitting electronic claims on the 837 transaction, call the Telephone Service Center (TSC) at the numbers listed below. Providers can request a Medi-Cal Now conference packet, which contains the following information:

- Telecommunications application and agreement
- Medi-Cal provider enrollment Frequently Asked Questions
- Requirements for submitting 837 version 4010A1 transactions
- Provider Relations Organization (PRO) TSC phone list and menu prompts
- CMC enrollment procedures and checklist
- 837 transaction Webcast CD

In addition, instructions for CMC submissions can be found on the Medi-Cal Web site by clicking the "CMC" link in the Provider Resources section on the home page.

Please see **Electronic Claim Transactions**, *page 2*

Electronic Claim Transactions *(continued)*

To further support your transition, Medi-Cal has implemented a self-service validation tool, the HIPAA Transaction Utility Tool. This tool is free and provides everything needed to exchange Electronic Data Interchange (EDI) files with Medi-Cal. This Web-based validation tool allows providers to test transaction compliance with Medi-Cal specifications. The tool also contains documentation such as EDI specifications (Companion Guides) in a format that can be browsed online or easily downloaded.

The HIPAA Transaction Utility Tool is accessed from the sysdev Medi-Cal Web site Transaction Services page (**http://sysdev.medi-cal.ca.gov**). We strongly encourage you to take advantage of this service.

- Click the "Transaction Login" link from the sysdev Medi-Cal home page.
- Enter your current Medi-Cal submitter ID and password. Your submitter ID must be prefixed with "CMCSUB" and the password is the same password you use for CMC dial-up access. Click "Submit."
- The "Transaction Services" menu will appear. Click the "HIPAA Transaction Utility Tool" link. A separate window will open for the application.
- After you have opened the Transaction Utility Tool application, you can click on the User Guide link located in the left navigation bar for step-by-step use and instruction.

For more information, in-state providers may call the TSC at 1-800-541-5555, from 8 a.m. to 5 p.m., Monday through Friday. Border providers, software vendors and out-of-state billers who bill for in-state providers should call (916) 636-1200. To learn more about other vision care-related HIPAA changes, refer to the "Vision Care Changes Coming Soon" link in the "HIPAA News" section of the Medi-Cal Web site.

End Stage Renal Disease Pilot Project

Under a four-year pilot project, recipients with End Stage Renal Disease (ESRD) may enroll in "VillageHealth operated by SCAN Health Plan" (VillageHealth), a Medicare Health Maintenance Organization (HMO). Effective for dates of service on or after January 1, 2006, VillageHealth serves recipients in select ZIP codes in San Bernardino and Riverside counties. Ordinarily, recipients with ESRD would be excluded from enrollment in a Medicare HMO.

VillageHealth is partnering with DaVita and other providers in this endeavor, as follows:

- VillageHealth (an ESRD Specialty Health Plan/California Medical Services Demonstration Project) is the primary payer
- DaVita renders the dialysis services
- Other providers may render additional medical services

Provider Manual
Policy about this pilot project has been added to the *MCP: Special Projects* section of the Part 1 Medi-Cal provider manual.

Billing
Providers bill for services to VillageHealth members as follows:

- Plan-covered services to VillageHealth
- Copayments, coinsurance or deductibles for plan-covered services to Medi-Cal (billed like a crossover claim)
- Services denied or not covered by VillageHealth, to Medi-Cal as standard fee-for-service claims

Please see **VillageHealth**, *page 3*

VillageHealth *(continued)*

Copayments, Coinsurance and Deductibles

Claims for copayments, coinsurance or deductibles must be submitted as paper claims. Instructions for submitting paper claims closely parallel instructions for billing Medicare/Medi-Cal hard copy crossover claims, except for the few additional requirements noted below. Therefore, billers should refer to the "Hard Copy Submission Requirements for Medicare Approved Services" in the Part 2 manual.

In their interpretation of the manual, billers should consider "VillageHealth" the same as "Medicare." For example, in the *Medicare/Medi-Cal Crossover Claims: Vision Care* section, under the "Where to Submit Hard Copy Crossover Claims" heading, the reference to "Medicare approved service" would be interpreted as "VillageHealth approved service."

In addition, claims for copayments, insurance or deductibles treated like crossovers must be billed to Medi-Cal with the same national procedure codes and modifiers billed to VillageHealth and include the following:

- A copy of the *Remittance Advice* (RA) received from VillageHealth. The RA must state "SCAN ESRD PILOT" in the *Remarks* section at the bottom left and include the address and telephone number for VillageHealth in the upper right corner.
- VillageHealth AEVS (Automated Eligibility Verification System) carrier code "S323" in the *Insurance Plan Name or Program Name* field (Box 11c) on the *HCFA 1500.*

Electronic billing may eventually be an option.

This information is reflected on manual replacement pages mcp spec 7 and 8 (Part 1) and medicare 3 (Part 1).

Instructions for Manual Replacement Pages — Part 2

March 2006

Vision Care Bulletin 337

This *Medi-Cal Update* does not contain Part 2 Billing and Policy provider manual pages.